MPPF OOPC Questions and Answers

1) What is the implication of the Medicare Personal Plan Finder for recent efforts to highlight Medicare+Choice (M+C) enrollment of ethnic groups?

   Ken Thorpe's recent analysis showed that lower income and beneficiaries in certain ethnic groups are more likely to enroll in M+C. For instance, nationally 40.3% of African Americans and 51.6% Hispanics that have a choice of an M+C plan enroll in one.

   These enrollees have recognized that M+C plans tend to offer better benefits than Original Medicare, at a lower cost than Medigap. The Medicare Personal Plan Finder supports this perspective, showing that for each of the different health conditions, from excellent to poor health, and all age groups, the majority of M+C plans have lower out-of-pocket expenses than fee-for-service Medicare with or without Medigap.

2) Does the Medicare Personal Plan Finder show that fee-for-service Medicare is cheaper than M+C for some beneficiaries?

   While the majority of M+C plans have lower out of pocket expenses than fee-for-service Medicare, there are some M+C plans that may cost more for beneficiaries in good health. However, healthy people should still consider all their options because M+C plans can protect them from higher out of pocket costs if their health status changes due to injury or illness. In addition, M+C plans offer many preventive benefits such as physical exams and disease management programs to keep beneficiaries healthy.

   To help people understand how costs vary due to health status, a number of enhancements have been made to the tool. This includes the addition of the out of pocket costs for the 95th percentile and out of pocket costs for several chronic/acute conditions (diabetes, congestive heart failure, and heart attacks). In addition, a new section has been added to help users understand how to use the out of pocket costs and how to interpret differences in out of pocket costs between health plan options.

3) Will the MPFF results be difficult for consumers to understand?

   Considerable effort has been undertaken to ensure that the results are "consumer-friendly" and easy-to-understand. A number of the enhancements made to address consumer findings. In addition, as with any of our web site releases, we are committed to continuing to improve the tool over time based upon actual user feedback and continued consumer testing.

4) Does MPPF encourage beneficiaries to only obtain coverage when they are sick?

No. We believe that the MPPF assists users in understanding that there are differences in the coverage offered by various health plan options and provides tips as to how to use the out of pocket cost comparisons to better understand the benefits offered. The MPPF stresses that out of pocket cost comparisons are but one of the factors that need to be considered when making a health insurance decision. Further, MPPF stresses that, particularly for Medigap insurance, an individual may not be able to purchase the insurance he/she wants after his/her initial enrollment period.

In addition, language has been added explaining that users need to consider the possibility of unexpected high health care costs, stressing that even the many healthy people can experience high health care costs. To emphasize this, the tool has been modified to add the out of pocket costs for the 95th percentile for each of the 30 age/health status categories and to provide out of pocket costs estimates for persons with chronic disease (diabetes and congestive heart failure), and an acute episode of illness (a heart attack).

We believe that these enhancements put the out of pocket cost comparison results in perspective and assist the user in determining how to use the results. As indicated above, we are committed to continuing to refine the tool as well as the methodology on an ongoing based on user input and feedback.

5) Who has CMS shared the OOPC Methodology With?

During the development of the methodology, CMS provided the OOPC methodology to experts including actuaries, health economists, and health plan managers. These experts included consultants from inside and outside of government, as well as those within the health plans and Medigap insurers. An onsite meeting was held on January 17, 2002 with the reviewers to discuss in detail the method to compute the out-of-pocket costs. Below is the list of invitees and those who attended:

List of External Invitees:	List of External Attendees:
➢ Tom Rice, UCLA School of Public Health ➢ Robert Power, Health Partners, Inc ➢ Bryan Curley, Wellpoint Health Networks ➢ John Bertko, Humana, Inc. ➢ Donald Sheak, United Health Group ➢ Bill Wrightson, Aresearch ➢ David McKusick, Aresearch ➢ Dan Zabinski, MedPac ➢ David Steinberg, Kaiser Permanente ➢ Mary Beth Senkewitz, National Association of Insurance Commissioners	➢ Robert Power, Health Partners, Inc ➢ Bryan Curley, Wellpoint Health Networks ➢ John Bertko, Humana, Inc. ➢ Steve Russel, Humana, Inc. ➢ Bill Wrightson, Aresearch ➢ David McKusick, Aresearch ➢ David Steinberg, Kaiser Permanente ➢ Dotti Outland, United Health Group ➢ Donald Sheak, United Health Group

➢ *Tim Koenig, United Health Group ➢ *Howard Bedlan, National Council on Aging ➢ *Gail Lawrence, American Republic Insurance Co. ➢ *James Cosgrove, GAO ➢ *Lu Zawistowich, MedPac ➢ *William Weller, Health Insurance Association of America ➢ *David Shea, Trigon Blue Cross Blue Shield Association ➢ *Michael Abroe, Milliman USA	

*Invitees who did not respond to the invitation and were not sent the methodology package.

In addition, the full methodology is available on www.cms.hhs.gov/healthplans/ . Select Medicare Personal Plan Finder: Methodology for Computing Out-of-Pocket Cost Estimates.

6) How has CMS kept the industry informed of the progress of the Out of Pocket Cost Estimates during development?

Many meetings and briefings have been held to discuss the OOPC methodology and data display. Dates and attendees include:

- April 22 – HIAA, BCBSA, and AAHP
- April 24 – Quarterly NMEP meeting
- May 1 – Medicare + Choice ACR seminar
- June 9 – Quarterly NAIC conference
- July 18 AAHP Industry Council meeting.

In addition to the above briefings, the following plan preview opportunities were offered:

- June 17 - AAHP, BCBSA, HIAA
- June 17-19 – Medicare + Choice plans had an opportunity to preview their own data
- June 21 - AARP previewed the Medicare + Choice and Medigap plan OOPC data
- Sneak preview of full site at www.cms.hhs.gov/healthplans has been available to plans from July through August 15.

7) Have M+C organizations been given sufficient opportunity to review and comment on the MPPF out of pocket cost estimates?

M+C organizations have been involved in the development of the methodology for over a year. Numerous stakeholder briefings have been provided; the detailed documentation has been shared and comments have been sought and responded to. Methodology changes have been made based on input from M+C organizations and others. In addition, a several hour long meeting was held in January to discuss methodology and feedback to ensure that there was ample opportunity to reach mutual understanding of issues and resolutions. All plans were given an opportunity to preview their data in June and have had a "sneak preview" of the web site, including the data, on a continuous basis from July – August 15. CMS responded to every comment received during the preview opportunity and thoroughly investigated each comment to identify any potential flaws in the methodology. Additional changes to the methodology were made as issues were identified – e.g., we added the consideration of the overall plan maximum limit on out of pocket costs as a result of issues raised at the July 18 AAHP industry council meeting. We are and will continue to work with plans that have specific questions about their results and have asked the industry to encourage their members to contact us with specific issues/questions.

8) Some Medicare + Choice plans have expressed concerns that the OOPC data will portray them in a more favorable light for sicker populations (i.e., persons of fair and poor health). These plans fear this will result in adverse selection. Is this what the data show?

The out-of-pocket costs for Medicare + Choice plans increase in direct proportion to worsening health. Chart 1 below shows the Medicare + Choice dollar sign distribution by health status.

Chart 1: Medicare + Choice plan out of pocket cost estimate distribution by health status

Health Status	% of M+C Plans in $0-$300 Range	% of M+C Plans in $301-$501+ Range
Excellent	97%	3%
Very Good	90%	10%
Good	58%	42%
Fair	28%	72%
Poor	9%	91%

Overall, the majority of M+C plans have lower out-of-pocket cost estimates than FFS. Chart 2 below shows the distribution by health status.

Chart 2: Comparison of Medicare + Choice to FFS out of pocket cost estimates by health status

Health Status	% M+C plans with higher OOPC estimates than FFS*	% M+C plans with lower OOPC estimates than FFS*
Excellent	49.5%	50.5%
Very Good	37.9%	62.1%
Good	27.9%	72.1%
Fair	18.2%	81.8%
Poor	8.1%	91.1%

* There are 472 M+C plans with OOPC (out of pocket cost) estimates. There are 6 age categories for each health status. Thus, the "n" for this table is 2,832 for each health status.

While the majority of M+C plans have lower out of pocket expenses than fee-for-service Medicare, there are some M+C plans that may cost more for beneficiaries in good health. However, healthy people should still consider all their options because M+C plans can protect them from higher out of pocket costs if their health status changes due to injury or illness. In addition, M+C plans offer many preventive benefits such as physical exams and disease management programs to keep beneficiaries healthy.

9) Some external actuarial experts questioned the sample sizes used to calculate the OOPC estimates. How has CMS addressed this concern?

Fu Associates, Ltd., on behalf of CMS, performed a Standard Error Analysis for the OOPC estimates using the specialized statistical procedure provided by WESVAR. They applied WESVAR to the 2002 Fee-For-Service (FFS) and Medicare + Choice plan OOPC estimates for the 7,640 beneficiaries in the 1998 cohort. The initial analysis has focused on the levels of the resulting standard errors and their relationship to the cost estimates. The results suggest that the variation of the 30 age/health status OOPCs are at reasonable levels, relative to the average (mean) estimates of those costs.

10) Isn't the methodology flawed because it treats utilization patterns the same for FFS and managed care?

The methodology does use a fixed utilization pattern to compare out of pocket costs across all health plan options. There was considerable discussion about this decision in the development of the methodology and with the actuaries and researchers who attended the January meeting on the methodology. Some comments have been received indicating that this may adversely affect the plans as it does not take into consideration any impact of plan disease management and care coordination programs. In contrast, however, it also does not take into consideration increases in utilization resulting from additional services and lower co-payments that plans offer. In considering all these factors, and considering consumer use of the tool, CMS decided to fix utilization for out of pocket cost methodology for all health plan options – FFS, FFS with Medigap, and M+C plans. We wanted to ensure consumers had an "apples to apples" comparison as to how out of pocket costs vary. Introducing variable utilization along with variable benefit packages would be very difficult for consumers to interpret.

11) Is the MCBS cohort used to calculate the OOPCs a geographically representative sample?

The MCBS is a nationally representative sample. Our main goal in displaying the data is to provide an "apples to apples" comparison for consumers. As such, all plans are compared on the same utilization pattern. We believe this is a reasonable approach. However, we recognize that there may be some geographic differences that are not considered at this time and will consider them in future enhancements.

12) How can the out of pocket expense be higher for someone in better health, for example for someone in fair health as compared to someone in poor health for the same age category? Similarly, how can out of pocket costs in some cases be lower for older persons in the same health status?

The out-of-pocket cost estimate for a beneficiary in an age and health status category is based on their specific utilization and the costs of the plan benefits that they are receiving. It cannot be assumed that the OOPC estimate (which is a mean across all beneficiaries in a group) will go up or down as they age and their health status decreases. The OOPC estimate reflects variation in utilization rates and service mix as defined by specific age and self-reported health status categories in the Medicare Current Beneficiary Survey. Therefore, while plan benefit cost sharing may remain constant across all age and health status categories, the OOPC estimate may differ based on the variations in MCBS utilization across age and health status. For example, prescription drug utilization peaks in the 70-79 age range for 3 out of the 5 health care categories. We also see differences in dental costs with, in some case, dental costs being higher in the lower age/better health categories. The detailed description of the methodology used to compute the Out of Pocket Costs is available at http://www.cms.gov/healthplans/oopc_specs_6_20.pdf

13) How can the out of pocket cost for someone age 65-69 in excellent health be more than $200 per month?

The out of pocket costs computations include the plan's premium, the Medicare Part B premium, the cost sharing (based on the plan's benefits and cost-sharing structure), and 100% of the cost for any items or services not covered by the plan. So, for example, if a plan had a $50 per month premium and did not cover prescription drugs or dental care it might have mean annual out of pocket costs such as the following for a 65 year old in excellent health.

- Part B premium $648
- Plan Premium $600
- Prescription drugs $638
- Dental $453
- Inpatient care $253

Plus miscellaneous other smaller out of pocket costs, resulting in total out of pocket costs of more than $2,592 annually or more than $216 per month.

14) How do you handle prescription drug out of pocket costs for a plan that does not cover prescription drugs? What if the plan only covers generic drugs?

If a plan does not cover prescription drugs, then 100% of the cost of the prescription drugs is considered out of pocket costs. If the plan only covers generic drugs, then the plan's cost sharing and limit, if any, would be applied to the generic drugs used by the sampled beneficiaries. The resulting out of pocket costs for the generic drugs plus 100% of the costs for the brand name drugs used by the sampled beneficiaries would be considered out of pocket costs for this plan. The methodology used to compute the Out of Pocket Costs explains this in more detail and is available at http://www.cms.gov/healthplans/oopc_specs_6_20.pdf

15) Results are counterintuitive. For example, why does Fallon Health plan with no premium, no inpatient co-payment, and $10 co-payment for physician visits have the same out of pocket costs as FFS.

This plan does not have the same out of pocket costs as FFS. In every category (i.e., all 30 age/health status categories, all 30 95th percentile categories by age/health status, and the 3 chronic/acute conditions), Fallon's out of pocket costs are LOWER than FFS. In one category, age 65-69 in excellent health, Fallon's out of pocket costs are lower than FFS but still within the same dollar range (i.e., both fall within the $151-$200 range). This categorization occurs because utilization is lower for those in excellent health so the lower cost-sharing offered by Fallon doesn't have as great an impact as in higher utilization age/health status categories.

16) What does the Out-of-Pocket Cost (OOPC) data show? Does Medicare FFS show lower out of pocket costs for Medicare beneficiaries than Medicare + Choice, both well and ill?

No. In some cases, FFS can look better than some Medicare + Choice plans in a given area for beneficiaries in excellent to good health. Utilization of services varies by age and health status. FFS has lower relative cost shares in some age/health status

categories with low utilization since FFS has no monthly premium (other than the Part B premium). Our data shows that the types of expenses that contribute the most to out-of-pocket costs are the following:

- **Prescription drugs (the highest contributor to out-of-pocket costs for people of almost every age and health group);**
- Medicare Part B monthly premium;
- Medicare + Choice or Medigap plan monthly premium (if any);
- Dental care expenses (particularly for people in excellent or very good health)
- Inpatient hospital expenses (particularly for people in fair or poor health).

In many case, FFS shows higher OOPCs in comparison to M+C plans due to the lack of prescription drug coverage. This is particularly true for many people with Medicare because the cost of prescription drugs is very high. See Attachment 1, an example of out-of-pocket cost comparisons for a California zip code.

Attachment 1: An example for zip code 90210 in CA.

a) Excellent Health, Age 65-69. In this example, the average monthly OOPCs for FFS is higher than or equal to the M+C plans based on excellent health. In addition, the costs for about 5% of beneficiaries are much higher in some cases for FFS than the M+C plans.

Plans	Average Monthly Out-of-Pocket Costs For a typical person age 65 - 69 in excellent health	Insurance Helps Protect Against the Unexpected Five percent (5%) of people age 65 - 69 in excellent health will have monthly out-of-pocket costs over:
Original Medicare	$151 - $200	$440+
Aetna U.S. Healthcare of California, Inc. Golden Medicare Plan	$151 - $200	$370+
Blue Cross of California Blue Cross Senior Secure	$151 - $200	$290+
Blue Shield of California, Inc. Blue Shield 65 Plus	$101 - $150	$210+
Health Net Of CA Health Net Seniority Plus	$151 - $200	$350+
Inter Valley Health Plan Service To Seniors	$101 - $150	$340+
Kaiser Permanente Health Plan, Inc. Kaiser Permanente Senior Advantage	$151 - $200	$380+
SCAN(tm) Health Plan SCAN Health Plan	$101 - $150	$150+
Secure Horizons Secure Horizons Standard Plan I	$101 - $150	$340+
UHP Healthcare UHP Healthcare for Seniors	$101 - $150	$190+
Universal Care Universal Care Health Advantage	$101 - $150	$250+

b) **Poor Health, Age 65-69**. This shows that the average monthly Out-of-Pocket Costs (OOPCs) for FFS is higher than the M+C plans based on poor health. In addition, the costs for about 5% of beneficiaries is much higher in most cases for FFS than the M+C plans:

Plans	Average Monthly Out-of-Pocket Costs For a typical person age 65 - 69 in poor health	Insurance Helps Protect Against the Unexpected Five percent (5%) of people age 65 - 69 in poor health will have monthly out-of-pocket costs over:
Original Medicare	$501+	$1,700+
Aetna U.S. Healthcare of California, Inc. Golden Medicare Plan	$401 - $450	$1,280+
Blue Cross of California Blue Cross Senior Secure	$401 - $450	$1,470+
Blue Shield of California, Inc. Blue Shield 65 Plus	$301 - $350	$710+
Health Net Of CA Health Net Seniority Plus	$351 - $400	$1,380+
Inter Valley Health Plan Service To Seniors	$301 - $350	$1,030+
Kaiser Permanente Health Plan, Inc. Kaiser Permanente Senior Advantage	$401 - $450	$1,400+
SCAN(tm) Health Plan SCAN Health Plan	$201 - $250	$310+
Secure Horizons Secure Horizons Standard Plan I	$351 - $400	$1,310+
UHP Healthcare UHP Healthcare for Seniors	$301 - $350	$830+
Universal Care Universal Care Health Advantage	$401 - $450	$1,560+